Adult Interview Forms Instructions

- 1. Authorization/Denial to Obtain or Release Information and Records
- 2. Case Management Contact Sheet
- 3. Confidentiality of Substance Abuse Client Records
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- 5. Face Sheet
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Authorization/Denial to Obtain or Release Information and Records

Use:

- To obtain the resident's consent to obtain information from or give information to relevant persons, programs, or organizations (including IHR, DSS, and DTA) wishing to receive or disclose relevant and specific information about the resident.
- This is a release form that can be used in place of the Consent for the Release of Confidential Alcohol or Drug Treatment Information.
- A release form can be used at any time during a resident's stay when information needs to be obtained or released.
- Either on the release itself or on the documents that the program is releasing "No Redisclosure" should be stamped to remind the receiving party that they should not disclose the information to another party.
- In the event that a resident revokes a release, a line may be drawn across the page and "release revoked" should be written with a date and signature.

Specialization/Enhancements:

- This form is used for the exchange of information contained in the resident's record or for the verbal exchange of information.
- This form provides options for information that is or is not to be released.
- This form provides a place to document that the resident refused to authorize communication with another person, program, or organization.

Regulatory Components that should not be deleted when tailoring to your program:

• It is strongly recommended that all staff attend confidentiality training.

- Family specific information is privileged and confidential and shall be made available according but not limited to 42 CFR Part 2, as amended. A consent to release of information is required to be signed by resident when program's release or obtain any information on the resident. According to page 9 of the guidelines, releases must contain the following:
 - The name of person/program permitted to make the disclosure.
 - The name of the person/program which the disclosure is to be made.
 - The name of the family member.
 - The purpose of the disclosure.
 - How much and what type of information to be disclosed.
 - The signature of the resident.
 - The date consent is signed.
 - The date or event upon the consent will expire.
- A statement of consent is subject to revocation at any time, except to the extent that the program/person, which is to make the disclosure, has already acted in reliance to it.

Case Management Contact Sheet

Use:

- This contact sheet can be used by the case manager to document conversations with collaterals or family members throughout the resident's stay at the program.
- This contact sheet can be used to inform case manager of conversations with collaterals or family that occur without the case manager present.
- The primary use of this contact sheet is for internal communication. It may be placed in the resident record.

Specialization/Enhancements:

• Staff completing the form should also note follow up that needs to occur by checking off the "follow up needed" box.

Regulatory Components that should not be deleted when tailoring to your program:

- This form is not required by DPH, BSAS guidelines.
- However, its use is strongly recommended by the team for a complete record.

Confidentiality of Substance Abuse Client Records

Use:

- This form is used to document that the resident's rights regarding confidentiality have been explained according to federal regulations 42 CFR, Part 2.
- Programs may give a copy of this form to the resident.

Specialization/Enhancements:

• The signature of the resident is not required, but it has been included on this form.

Regulatory Components that should not be deleted when tailoring to your program:

- Federal Regulations require that all federally assisted substance programs explain rights regarding confidentiality to substance abuse clients.
- This form is also required by DPH, BSAS guidelines.

Consent for Release of Confidential Alcohol or Drug Treatment Information

Use:

- To obtain the resident's consent to obtain information from or give information to relevant persons, programs, or organizations (including IHR, DSS, and DTA) wishing to receive or disclose relevant and specific information about the resident.
- This is a release form that can be used in place of the Authorization / Denial to Obtain or Release Information and Records.
- A release form is used at any time during a resident's stay when information needs to be obtained or released.
- Either on the release itself or on the documents that the program is releasing "No Redisclosure" should be stamped to remind the receiving party that they should not disclose the information to another party.
- In the event that a resident revokes a release, a line may be drawn across the page and "release revoked" should be written with a date and signature.

Specialization/Enhancements:

• This form is used for the exchange of information contained in the resident's record or for the verbal exchange of information.

Regulatory Components that should not be deleted when tailoring to your program:

- It is strongly recommended that all staff attend confidentiality training.
- Family specific information is privileged and confidential and shall be made available according but not limited to 42 CFR Part 2, as amended. A consent to release of information is required to be signed by resident when program's release or obtain any information on the resident. According to page 9 of the guidelines, releases must contain the following:
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 - The date consent is signed.
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- A statement of consent is subject to revocation at any time, except to the extent that
 the program/person, which is to make the disclosure, has already acted in reliance to
 it.

Face Sheet

Use:

- This form contains basic information about a resident's children, service providers, and emergency contacts.
- Programs can use this form where it fits best in their admission procedures. For example:
 - it can be completed before the Resident Intake Form and placed in front of the Resident Intake Form in order to keep all the resident information together.
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 - it can be completed during the initial resident interview and kept at the beginning of chart for quick reference.
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 - it can also be completed during orientation.

Specialization/Enhancements:

- This form is designed to aid staff in finding important information quickly.
- Checkboxes have been added to remind staff to obtain releases to speak to emergency contacts and other providers involved with the resident.

Regulatory Components that should not be deleted when tailoring to your program:

- This form is not required by DPH, BSAS guidelines.
- However, its use is strongly recommended by the team for a complete record.

Resident Intake Form

Use:

- This form can be used to determine if a candidate is appropriate for admission to the program.
- This form can also be used as a data gathering tool for the formulation of the Family Service Plan.
- This form gathers a comprehensive resident history and can be used to assess a resident's service needs.

Snecialization/Enhancements:

 This form includes a tobacco assessment section so a separate Nicotine Dependence Test is not needed.

Regulatory Components that should not be deleted when tailoring to your program:

- The DPH, BSAS guidelines require that the following information be collected at intake:
 - Social, economic, and family histories.
 - Educational and vocational achievement.
 - Criminal History.
 - Medical, drug, and drug treatment histories.